IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF OREGON

DEBORAH PLUM, Plaintiff, v. MICHAEL J. ASTRUE, Commissioner of Social Security, Defendant.	No. CV-08-6121-HU FINDINGS & RECOMMENDATION

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HUBEL, Magistrate Judge:

Plaintiff Deborah Plum brings this action for judicial review of the Commissioner's final decision to deny disability insurance benefits (DIB). This Court has jurisdiction under 42 U.S.C. § 405(g). I recommend that the Commissioner's decision be affirmed.

PROCEDURAL BACKGROUND

Plaintiff applied for DIB on June 29, 2004, alleging an onset date of October 31, 2001. Tr. 71-73. Her application was denied initially and on reconsideration. Tr. 37-38.

Plaintiff filed an untimely request for a hearing on June 17, 2005, but good cause was established for the late filing. Tr. 19. On February 16, 2007, plaintiff, represented by counsel, appeared for a hearing before an Administrative Law Judge (ALJ). Tr. 389-441. The hearing was continued to September 21, 2007. Tr. 442-64.

On October 26, 2007, the ALJ found plaintiff not disabled. Tr. 17-35. The Appeals Council denied plaintiff's request for review of the ALJ's decision. Tr. 5-7.

FACTUAL BACKGROUND

In a July 6, 2004 Disability Report (Form SSA-3368), plaintiff alleged disability based on diabetes, hepatitis C, pancreatitis, and "mental." Tr. 74. At the time of the February 2007 hearing, plaintiff was fifty-four years old. Tr. 71. She had turned fifty-five by the September 2007 hearing. Id. Plaintiff completed one year of college. Tr. 79. Her past relevant work is as a legal assistant. Tr. 32, 75-76.

I. Medical Evidence

The first medical record in the Administrative Record is an Emergency Department Report from McKenzie-Willamette Hospital dated

October 31, 2003. Tr. 146-47. Plaintiff went to the emergency room to obtain her regular supply of methadone which she was supposed to have received from her regular physician, Dr. Edward Reeves, D.O. Tr. 147. Apparently, Dr. Reeves had to leave his office suddenly due to an emergency and did not have time to make arrangements for his methadone patients. Id. Somehow, the Emergency Department at the hospital was informed that they could expect to see multiple methadone patients over the weekend, seeking enough to get them through to the following Monday, when Dr. Reeves would be back in his office. Id. Plaintiff was given ten doses of methadone and ten doses of Klonopin, a benzodiazepine used to treat panic disorder and anxiety. Id.

On December 2, 2003, plaintiff returned to the emergency room at McKenzie-Willamette Hospital, complaining of high blood sugar. Tr. 141-42. Plaintiff reported that because of financial problems, she had made the choice to discontinue all of her medications in order to maintain her home and eat. Tr. 141. She reported that she had prescriptions available for her oral hypoglycemics, but not for her methadone and Klonopin for her chronic neck pain. Id. Plaintiff stated that she was supposed to take two oral hypoglycemics, of which one was Metformin. Id. Other than what was noted as "her chronic pain issues," plaintiff stated she had no medical problems with no complications noted from her diabetes. Id. She did report a previous history of drug and alcohol abuse, indicating that it was "years ago," but stating that she had hepatitis C. Id.

At the time, plaintiff's blood sugar was 350, with an "acetone positive 1-4." Id. She was given four units of regular insulin,

but because of the absence of any records regarding her medications, the physician was unwilling to provide her with oral hypoglycemics. Id. She was instructed to follow up with her primary care physician the next day. Id. She was expressly told that the emergency department would not address her chronic pain issues, which she needed to address with her primary care provider. Id. The emergency department physician's "focus is [plaintiff's] diabetes which is not complicating at this point." Tr. 141-42. Plaintiff was warned that she would end up back in the same situation if she did not start her oral hypoglycemics at the appropriate dose. Id.

On March 21, 2004, plaintiff's son took her to the emergency room at Sacred Heart Medical Center when he arrived for a visit and found her lethargic and not functioning well. Tr. 160. Plaintiff's son reported that she had a history of methamphetamine use, and had been using it recently, as well as drinking alcohol. Id. Plaintiff initially denied the son's report, but then admitted it. Id. She did not use intravenous drugs, and reported taking methadone for chronic pain management. Id. Her urine tested positive for amphetamines. Tr. 158.

Plaintiff's blood sugar was over 1000, with a serum sodium of 160. Tr. 157. She was admitted to the hospital with hyperosmolar syndrome[1]. Id. She had lost weight and was described as almost

[1] According to the Mayo Clinic, hyperosmolar syndrome occurs in diabetics with blood sugars over 600; the "blood becomes thick and syrupy" and the excess sugar passes from the blood to the urine, which triggers a filtering process that draws tremendous amounts of fluid from one's body. Left untreated, it can lead to life-threatening dehydration. www.mayoclinic.com

emaciated. Tr. 157-58. Tr. 158. It was noted that she was a poorly maintained diabetic. Id.

While in the hospital, plaintiff was seen by Dr. David Calder, M.D., on March 24, 2004, for consultation regarding her diabetes care. Tr. 154-55. He noted that since her admission to the hospital, she had been treated with intravenous fluids and had responded favorably to that. Tr. 154. Dr. Calder noted that in addition to her problems with diabetes, plaintiff had a difficult social situation. Id. He noted that she was on chronic methadone therapy for neck pain secondary to an automobile accident. Id. He also noted her history of methamphetamine use and hepatitis C. Id.

Dr. Calder's impressions were diabetes mellitus with insulin deficiency, methadone use for chronic pain, and difficult social situation. Tr. 155. He discussed various options for management of her diabetes with her and decided the safest insulin would be Lantus, along with the use of NovoLog when she eats. Id. Dr. Calder noted that plaintiff's insurance coverage was questionable and that she might have the Oregon Health Plan. Id. He was unsure if it covered Lantus, but he thought he could keep her supplied with samples until she was improved, at which time she might need to switch to a different insulin regimen. Id. He agreed to follow her in regard to her diabetes, but noted she would need a different primary care physician to assist with other health care needs. Id.

At the time of her discharge on March 27, 2004, her primary diagnosis was hyperglycemic, hyperosmolar, nonketotic state with associated confusion. Tr. 149. Given her extremely thin state, plaintiff also had a nutritional status assessment by a dietitian. Id. She received a day of intensive education about her disease

process and voiced understanding of the process, the need to eat well, and the need to regularly monitor her blood sugars. Tr. 150. Her methadone dose was altered, to a total of 75 milligrams per day instead of 80 milligrams per day. Id. This seemed to improve her level of consciousness without affecting her pain control. Id. The discharge report notes that there was no evidence of current methamphetamine use at the time of the hospitalization. Id. Plaintiff was discharged home to the care of her husband. Id. Dr. Michael Laurie had agreed to accept her as a patient for primary care. Id.

After her hospital discharge, plaintiff followed up as an outpatient with Dr. Calder on April 9, 2004. Tr. 199-200. She had improved in monitoring her morning blood sugars, but was not doing as well in recording other blood sugars during the day. Id. Dr. Calder noted that he spent a lot of time discussing the proper insulin/carbohydrate ratio with plaintiff. He gave her a handout, asked her to keep a food diary, and to return to see a dietitian. Tr. 200.

Plaintiff saw Dr. Laurie on April 12, 2004 to establish care. Tr. 167-68. Plaintiff reported her past medical history to Dr. Laurie as including chronic neck pain from a 2000 motor vehicle accident for which she takes methadone for pain relief, diabetes, depression, and sleep disturbance. Tr. 167. As for her depression, she told Dr. Laurie that she had used multiple antidepressants in the past, but did not want to take them because they made her more depressed. Id. She stated she was not suicidal. Id. As for the sleep disturbance, she stated that she gets nightmares, but uses Klonopin to help with that. Id.

Plaintiff reported that she did not work, she smoked cigarettes, she had not used methamphetamines for a week, did not abuse alcohol, and used no injectable drugs. Tr. 168.

On physical examination, Dr. Laurie noted that plaintiff pointed to her left posterior trapezius muscle area where there was some discomfort, but her neck was supple. Id. He talked with her about her neck pain and told her she had to be compliant with her medications and could not have the prescriptions early. Id. Dr. Laurie also warned her that he would not fill them if she lost them. Id. He asked her to occasionally do a urine test to see if she was still abusing methamphetamines. Id. He did so, because in his opinion, she was at risk for being abusive with the methadone and could potentially do herself harm with "that and her depression." Id. He told her she needed to get her old medical records to document her need for the methadone, which he described as a "strong narcotic." Id. He renewed her prescription for Klonopin. Id.

Following her initial visit with Dr. Laurie, plaintiff returned to Dr. Calder on April 23, 2004, to follow-up with her diabetes care. Tr. 197-98. Dr. Calder noted how much better she looked compared to when he saw her in the hospital. Tr. 197. She had put on some weight, and was bright and alert. Id. She talked about going back to work. Id. He noted her struggle with financial problems and the lack of insurance to cover medications and insulin. Id. He indicated this was an ongoing issue, although he remarked the situation might improve if she went back to work. Id.

He noted that she was working hard to count carbohydrates.

Id. Although she was unable to do the ideal amount of blood sugar testing because of her inability to buy strips, she had done some and Dr. Calder reviewed the information with her. Id. Dr. Calder thought plaintiff would be able gain control of the disease at some point. Tr. 198.

Plaintiff's next visit with Dr. Laurie was May 12, 2004. Tr. 165-66. In general, plaintiff was feeling better, although she had a possible urinary tract infection. Tr. 165. He noted that her affect was good and that she had gained some weight. Id. Dr. Laurie remarked that plaintiff stated that because of stress, she thought she needed to take the Klonopin twice per day instead of just once at night. Id.

Dr. Laurie noted that he had reviewed plaintiff's records which showed a history of elevated alkaline phosphatase level and elevated blood sugar. Id. He filled her prescription for methadone and told her she could ask for it monthly. Id. He wrote her a prescription for twice daily Klonopin. Id. He referred her to a female gynecologist for routine gynecologic care. Id.

The records show no additional visits with Dr. Laurie. Plaintiff saw Dr. Calder again on June 1, 2004, and he reported that while she was still struggling with her blood sugars and the insulin/carbohydrate ratio, she showed marked improvement in her level of understanding and management. Tr. 195-96. However, by the time she saw him again on July 15, 2004, the degree of control she had over her diabetes was unclear. Tr. 193. Dr. Calder noted that she did not bring in any blood sugar records and she failed to get some laboratory tests done after he had ordered them in June. Id.

On July 12, 2004, plaintiff established care with Dr. Sharon Meyers, D.O. Tr. 218-19. Plaintiff's primary complaint was about the reduction in her dose of methadone, which she reported had been 120 milligrams per day before it was changed. Tr. 218. She said she was not doing well on the reduced dose. Id. Plaintiff told Dr. Meyers that she had lost quite a bit of weight in the previous year because of financial problems which precluded her access to food. Tr. 218-19. She also stated that she was "coming around with regard to that," even though she reported having quite a bit of stress in her life. Tr. 219.

Dr. Meyers started plaintiff on Enalapril, a drug used to treat hypertension. Tr. 219. She refilled her methadone at 40 milligrams, three times per day, because this is what plaintiff reported was her previous dose. Id. Dr. Meyers indicated she would see plaintiff again in three months, or sooner if needed. Id.

On August 23, 2004, a Psychiatric Review Technique Form (PRTF) rated plaintiff as having a not severe impairment. Tr. 173. Although it noted that she had a non-specified anxiety disorder, it also noted that she had behavioral changes or physical changes associated with the regular use of substances that affect the central nervous system. Tr. 181. The anxiety-related disorder was noted, as was liver damage. Id. The PRTF notes her methamphetamine abuse, and methadone maintenance therapy. Id.

In the "B" listing of functional limitations, plaintiff was rated as having mild difficulties in social functioning, and mild difficulties in maintaining concentration, persistence, or pace. Tr. 183.

On September 8, 2004, plaintiff saw Dr. Calder again, apparently for the last time as there are no other records of visits with him in the Administrative Record. Tr. 190-91. Dr. Calder noted that plaintiff had "fallen off the wagon a little bit" with her blood sugar monitoring. Tr. 190. Nonetheless, overall, Dr. Calder noted that she had improved control and he congratulated her on her efforts. Tr. 191.

Plaintiff complained about pain in her right foot. Id. She described pain in the distal metatarsal region when she put weight on the foot first thing in the morning. Id. The pain went away as she walked around. Id. On physical exam, her foot appeared normal with no tenderness. Id. Dr. Calder diagnosed her with metatarsalgia. Id. He discussed the management of this condition with her. Id. He indicated that she should see him again in three months. Id.

Plaintiff returned to Dr. Meyers on November 24, 2004. Tr. 216-17. Plaintiff told Dr. Meyers she had not been compliant with her medications because she had not taken her blood pressure pills that day. Id. Plaintiff reported being under a lot of pressure because she was trying to rent a home. Id. Plaintiff's physical exam was routine, and in the section remarking on her mental status, Dr. Meyers noted that her affect was normal. Tr. 217. Dr. Meyers assessed her diabetes as being in "questionable control." Id. She indicated plaintiff should follow up with her in three months. Id.

On February 4, 2005, plaintiff returned to Dr. Meyers for follow up. Tr. 214-15. Between her last visit and this one, plaintiff had been incarcerated and was taken off Klonopin during

that time. Tr. 214. Dr. Meyers expressed concern about plaintiff's failure to obtain blood work as ordered. Dr. Meyers also told plaintiff she would not refill the Klonopin until plaintiff saw a psychiatrist. Tr. 215. No physical exam was performed, but Dr. Meyers described plaintiff as being fairly agitated and emotionally distraught. Id. She assessed plaintiff as having diabetes with questionable control, and anxiety with possible drug seeking behavior. Id. She asked plaintiff to get the blood work done and advised her that they may not be able to continue with the doctor-patient relationship if plaintiff could not be more compliant. Id.

On March 29, 2005, Dr. Meyers noted that plaintiff's incarceration, which she first noted in her February 4, 2005 chart note, lasted nine days, during which plaintiff did not receive Klonopin or methadone. Tr. 209-10. Plaintiff did have her diabetes-related blood work done and Dr. Meyers noted that while her hemoglobin Alc was high, the rest of her numbers were good. Tr. 209. Dr. Meyers assessed plaintiff's diabetes as being in poor control. Tr. 210. Although the Administrative Record contains no record of a visit by plaintiff to Dr. Calder after September 8, 2004, Dr. Meyers's March 29, 2005 chart note states that plaintiff was seeing Dr. Calder for her diabetes care. Tr. 210.

On June 9, 2005, Dr. Meyers reported that plaintiff was homeless, although she and her family were staying with someone. Tr. 207. Plaintiff had no medical complaints, although plaintiff reported that her husband had told her that she had had at least two seizures. Id. Plaintiff's husband was not present to further describe the incidents. Id.

Plaintiff's blood pressure was elevated. Tr. 208. Dr. Meyers recommended that plaintiff check her blood pressure as an outpatient and to keep close tabs on her insulin. Id.

The last time plaintiff saw Dr. Meyers was on August 16, 2005. Tr. 204-05. In contrast to her other visits which had been to establish care, review her diabetes wellness plan, and check her medications, this time plaintiff complained of pain as her chief complaint. Tr. 204. Specifically, knee, elbow, and shoulder pain are noted in the "chief complaint" section of the chart note. Id.

Dr. Meyers wrote that plaintiff came in to try to negotiate pain medications. Tr. 204. Plaintiff wanted to change from taking forty milligrams of methadone three times per day, to four times per day. Id. Dr. Meyers noted that plaintiff's situation and history changed frequently. Id. As an example, she noted that plaintiff had been telling her for several months that she was going to move to the coast, but presently told her that she had a part-time job in Eugene. Id. She expressed comfort with Dr. Meyers's care, but Dr. Meyers told plaintiff that she was not a chronic pain management doctor. Tr. 204-05.

Despite the pain complaints in the "chief complaint" section, Dr. Meyers noted that plaintiff was in no acute distress. Tr. 205. Her impression, however, was of chronic pain. Id. Dr. Meyers planned to ask Debra Blaker to see plaintiff as it was out of Dr. Meyers's area to treat for chronic pain management. Id. She indicated she would see plaintiff in three months, or sooner if needed. Id.

The next appointment plaintiff had with a physician was on October 12, 2005, with Dr. Wendell Tollerton, in Astoria. Tr.

231.[2] Dr. Tollerton noted plaintiff's history of diabetes and remarked on her self-report of "neuro" in feet. Id.; Tr. 222. He further noted her history of hypertension for which she takes Enalapril. Id. Next, he recorded her self-report of anxiety with nightmares for which she takes Klonopin. Id. He also remarked on her complaint of radiculopathy following a 2000 motor vehicle accident, with pain now moving from right shoulder to left knee, and radiculopathy in the left shoulder. Id.

On physical examination, plaintiff was able to abduct her arms to 120 degrees to the right with a "9/10 dull pain." Tr. 222. She was able to forward flex her right shoulder to 120 degrees also. Id. She had no impingement sign either on the right or left. Id. Her gripping, flexing, and extension were 5/5 on the left side. Id. The right side showed "subjective decrease in strength but scale of 5/5." Id.

Dr. Tollerton assessed plaintiff as having diabetes with neuropathy, hypertension, c-spine radiculopathy, anxiety, and a

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[2] The record is a bit unclear about what date Dr. Tollerton actually first saw plaintiff. His handwritten record bears the date of October 12, 2005. Tr. 231. This is confirmed by a separate record of medications prescribed by Dr. Tollerton which show four prescriptions ordered for plaintiff on that date. Tr. 238, 240. Typically, Dr. Tollerton's records have a handwritten "SOAP NOTE," for each visit, with a typewritten Progress Note repeating the information found on the handwritten page. E.g.. Tr. 226 (handwritten SOAP NOTE for November 11, 205), and Tr. 224-25 (typed Progress Note for same visit).

The typed Progress Note which repeats the information found on Dr. Tollerton's handwritten October 12, 2005 SOAP NOTE, bears the date of November 12, 2005, rather than October 12, 2005. Tr. 222-23. I assume that this is an error, and the Progress Note dated November 12, 2005, is actually the Progress Note for the October 12, 2005 visit.

toothache. Id. He prescribed penicillin for the toothache, diabetes medications, Enalapril for her hypertension, and Klonopin. Tr. 22-23. Although there is no remark in either the handwritten SOAP NOTE or the typed Progress Note from that October 12, 2005 visit, the medication record shows that he also prescribed methadone, forty milligrams, every eight hours. Tr. 240.

Dr. Tollerton saw plaintiff again on October 27, 2005. Tr. 229. Dr. Tollerton noted that plaintiff stated that she walked two to three miles per day, even though he reported her as having neuropathy in her feet. Tr. 229. No other relevant changes were noted in her Progress Notes for that visit. Id.

On November 11, 2005, Dr. Tollerton saw plaintiff again to follow up on her diabetes, hypertension, radiculopathy, and anxiety. Tr. 224-25. At this visit, plaintiff reported that she walked at least five miles per day. Tr. 224. Dr. Tollerton noted that she had pain in her shoulders and knee which was probably degenerative joint disease. Id. He stated that the radiculopathy was probably c-spine. Id. Dr. Tollerton noted that plaintiff does not eat a diet which was compatible with keeping her diabetes under control. Id. He asked her to get her eating cycle to agree with the times the kitchen at the shelter where plaintiff was currently staying, was open. Id. He refilled her methadone and Klonopin. Id.

Plaintiff apparently saw Dr. Tollerton again in late January 2006. The exact date appears to be January 27, 2006, but it is unclear from Dr. Tollerton's handwritten SOAP NOTE and there is no corresponding typewritten Progress Note for the visit. Tr. 221. No apparent changes in plaintiff's condition are noted. Id.

Plaintiff continued to walk five miles per day and her hypertension continued to be well controlled. Id. She continued to complain of pain in her right shoulder, although her knees were reported to be "ok." Id. Dr. Tollerton noted plaintiff's complaint that she was not sleeping well. Id. He made some adjustments to her diabetes medications. Id.

Plaintiff did not keep her February 3, 2006 appointment with Dr. Tollerton. Tr. 220. The last record from his office is the medication list showing that he renewed prescriptions for insulin and Klonopin on March 6, 2006. Tr. 238.

On April 7, 2006, plaintiff was seen by Dr. Raymond Baculi, M.D., at the Salem Clinic. Tr. 242-43. Plaintiff reported having diabetes and hypertension. Id. Plaintiff also complained of an increased depressed mood. Tr. 242. Plaintiff told Dr. Baculi that in the past, she had been taking the antidepressant amitriptyline, but had not taken it in a number of years. Id. She was currently homeless. Id.

Dr. Baculi assessed plaintiff as having diabetes, hypertension, and depression. Tr. 243. He continued her on her current diabetes medications, continued her on her hypertension medication, and restarted her on amitriptyline. Id. He advised her to return in one month. Id. A May 2006 chart note indicates that plaintiff moved to Eugene and planned to transfer her care to a different doctor. Id.

There are no medical records from any practitioner between Dr. Baculi's April 7, 2006 visit, and a March 2007 report by psychologist David Northway, Ph.D., whom plaintiff saw for a neuropsychological consultation. Tr. 283-91. After missing her

first appointment, she appeared on-time for a rescheduled appointment on March 14, 2007, but was too tired and performed too slowly to finish the assessment at that time. Tr. 283. She then arrived an hour late to her next appointment on March 23, 2007. Id.

Dr. Northway started his report by noting that plaintiff appeared somewhat disjointed and rambling in her presentation and responded very slowly both to formal questions and resting as well as to interview. Tr. 284. He stated that "[h]er level of honesty could not be clearly determined. There was a slightly over-dramatic sense to her presentation." Id.

Plaintiff reported to Dr. Northway that she never used methamphetamine willingly, but claimed that someone had given her methamphetamine and told her it was Fen-Phen, a diet drug. Tr. 285. She denied any intravenous drug use, but admitted to trying heroin approximately fifteen years earlier. Id. She reported that she eventually lost her house as a result of her drug problems. Id. Although she told Dr. Northway that she last used marijuana about six months earlier, Dr. Northway stated that it was difficult to clearly follow her responses regarding her marijuana use. Id. She was hoping to get her current physician, a Dr. Bovee, to sign a medical marijuana card for her, which she believed would help her pain. Id. She told Dr. Northway that she intentionally went off all her pain medications and benzodiazepines because she thought that would help her obtain disability benefits from Social Security. Id. She was using methadone for pain management. Tr. 285, 289. Plaintiff also told Dr. Northway that she had been arrested for shoplifting food. Tr. 285.

Plaintiff described her mood as "mostly depressed." Tr. 286. She reported that she had had "multiple little attempts" when asked about suicidal ideation. Id. She reported that November 2005 was the last time she had tried to cut her wrists. Id. She told Dr. Northway that she was taken to the emergency room, but was not kept overnight. Id.

Dr. Northway administered the following neuropsychological tests: (1) Wechsler Adult Intelligence Scale, Third Edition; (2) Wechsler Memory Scale, Third Edition; (3) Trail Making Test; (4) Reitan-Indiana Aphasia Screening Test; and (5) Personality Assessment Inventory. Tr. 287-89.

In the discussion and impression section of his report, Dr. Northway noted that the neuropsychological testing "was not strongly suggestive of serious deficits except that she seems to process visual spatial information quite slowly." Tr. 289. Her scores on several tests were consistent with this. Id. Dr. Northway noted that lack of mental efficiency could be correlated with higher levels of depression, but otherwise, her cognitive functions were relatively intact. Id. Intellectually, she was in the average to low average range. Id. "From a cognitive perspective, she might be expected to complete tasks more slowly than her peers and it is unclear whether or not she could work competitively if speed and efficiency are primary concerns of an employer." Id.

In this part of his report, Dr. Northway noted that plaintiff seemed to be suffering from a number of Axis I and Axis II problems, which would have an impact on her ability to interact with others. Id. She demonstrated signs indicative of a

borderline personality disorder, with some anti-social features. Id. Dr. Northway further noted that plaintiff seemed to have post-traumatic stress disorder. Tr. 289. He did not articulate the basis for this remark in this section of his report, but in his discussion of the Personality Assessment Inventory test, Dr. Northway remarked that there were aspects of plaintiff's profile suggesting the presence of post-traumatic stress disorder "symptomology." Tr. 288. He does not further elaborate what those aspects were. Id.

In the discussion and impressions section, Dr. Northway further noted that plaintiff seemed to have depression, although again, he does not cite the source for that conclusion in that section. Tr. 289. He also noted that she reported a history of conflicts in relationship in various settings and would not be an easy person to work with cooperatively or collaboratively. Id. Dr. Northway remarked that plaintiff could be volatile quite easily and that her emotional lability was apparent even in the course of his assessment. Id.

Dr. Northway stated that plaintiff complained of a number of physical problems and chronic pain, which he suggested be carefully evaluated by an appropriate medical provider. Id. He noted that it was not clear if her diabetes was always carefully controlled. Id.

In his Axis I diagnostic impressions, Dr. Northway listed (1) dysthymic disorder, (2) rule out major depressive disorder, recurrent, moderate, (3) pain disorder associated with general medical condition and psychological factors, and (4) anxiety with features of post-traumatic stress disorder and obsessive-compulsive

disorder. Tr. 290. In his Axis II diagnostic impression, he listed non-specific personality disorder with significant features of borderline, anti-social, and dependent personality disorders present. Id. Dr. Northway rated her Global Assessment of Functioning (GAF) score as 50. Id.

Dr. Kurt Brewster, M.D. conducted an independent internal medicine examination of plaintiff on March 26, 2007. Tr. 258-70. Dr. Brewster performed a thorough physical examination and medical record review. Id. He concluded first that plaintiff's diabetes was well documented in the chart and despite her statement to him that she had never been able to get the disease under control, the records showed that when she adhered to her insulin, she was able to manage it. Tr. 269. He noted, however, that her current homelessness had to be taken into account and that storage of diabetes medication may be difficult and affect her compliance. Id.

Next, he stated that on physical testing, plaintiff had preserved lower extremity vibration and light touch sense. Id. There was an absence of sharp touch. Id.

Dr. Brewster found plaintiff's complaints of chronic pain less clear. Id. Although she alleged that a 2000 motor vehicle accident left her with resultant neck pain requiring ongoing methadone use, there was no history of neck x-ray, MRI, or nerve conduction studies. Id. Thus, Dr. Brewster noted it was in "this area where discrepancies are noted." Id. Plaintiff took off her coat and abducted her arm to 170 degrees spontaneously, but on testing she showed marked limitation on abduction to 80 degrees. Id. She also had no evidence of left forearm atrophy and motor

strength was preserved in all areas. Id. Dr. Brewster found that the medical records had not established an objective basis for plaintiff's neck pain. Id.

Finally, as to her feet, he noted that there was a loss of sharp touch sensation over the plantar surface of the feet in the face of poorly controlled diabetes. Id. This may have been partly attributable to her living situation. Id.

In terms of her functional assessment, Dr. Brewster opined that plaintiff could walk/stand for about six hours in an eight-hour day, and had no sitting restrictions. Id. She needed occasional restrictions on balancing, climbing, and crawling given the loss of sharp sensation in her feet. Tr. 270. As for environmental limitations, Dr. Brewster stated that because of her loss of sharp touch sensation and her uncontrolled diabetes, she was at "increased risk," and would have to avoid areas where she would encounter trauma. Id.

At about the time plaintiff was examined by Dr. Northway and Dr. Brewster, she received a psychodiagnostic assessment by psychologist Pamela Joffe, Ph.D. Tr. 248-57. Dr. Joffe met with plaintiff on March 24, 2007, March 27, 2007, and April 3, 2007. Tr. 248.

Dr. Joffe reviewed plaintiff's medical records and administered the following tests: (1) Calculation subtest-Woodcock Johnson III, Tests of Achievement; (2) the Information and Orientation, and Mental Control subtests from the Wechsler Memory Scale, Revised; (3) the Digit Span Subtest from the Wechsler Adult Intelligence Scale, Third Edition; (4) the Beck Depression Inventory-Second Edition; and (5) the Minnesota Multiphasic

Personality Inventory-Second Edition (MMPI-2). Id.

Dr. Joffe noted that plaintiff was fatigued and somewhat irritable. Tr. 251. Plaintiff told Dr. Joffe that she had cut herself with a razor in 2004, and had since taken too many Klonopin at times, but was not currently suicidal. Tr. 252.

Dr. Joffe's Axis I diagnostic impressions were (1) mood disorder (anxiety and depression) due to general medical condition (diabetes), (2) physical abuse as a child, and (3) nicotine dependence with a prior history of alcohol and methamphetamine use. Tr. 253. She rated her GAF as 50. Id.

Dr. Joffe noted that plaintiff was able to understand and remember instructions during the interview. Tr. 254. However, she noted that plaintiff's ability to understand and remember more complicated instructions would fluctuate depending upon how much sleep she had the night before, and her blood sugar. Id. Dr. Joffe further noted that interpersonally, plaintiff reported no current difficulties, but having been hurt in the past, she would tend to avoid contact with others. Id. She had adequate communication skills. Id.

On April 18, 2007, plaintiff went to "Options" Counseling in Eugene, Oregon, and received an Adult Initial and Psychosocial Comprehensive Mental Health Assessment from Patti Bear, M.A. Tr. 276-81. The report states that plaintiff "came in crisis," complaining about being homeless, being unable to get refills of her pain medications, and being unable to stay at "the Mission" because of her use of syringes for insulin. Tr. 276. Although she reported that she would "rather put a bullet in my head than live like this," she also told Bear that she had a religious conflict

with these feelings and thinks it is wrong to take one's own life. Tr. 277. She told Bear that she had tried to slit her wrists on November 19, 2005, when she was kicked out of a shelter in thirty degree weather. Id.

Bear's Axis I diagnoses for plaintiff were (1) generalized anxiety disorder; (2) major depressive disorder, moderate; and (3) rule out attention deficit hyperactivity disorder. Tr. 280. She rated her current GAF as 30. Id. Bear recommended therapy and a medication consultation. Tr. 281. She was given an appointment with a psychiatric mental health nurse practitioner. Id. There are no records of plaintiff keeping such an appointment in the Administrative Record.

Plaintiff went to the emergency room at Sacred Heart Medical Center in Eugene on April 23, 2007, with a chief complaint of hyperglycemia. Tr. 356. She reported that her feet hurt because of diabetic neuropathy, and that her prescriptions were waiting for her in a pharmacy on "River Road," and she could not walk there to obtain them. Id. She was staying with a friend, but explained that before that, her medications and syringes had been stolen so she had not regularly been taking her insulin. Id. She was upset with Dr. Bovee, whom she described as her previous primary care practitioner. Id. She stated that he had not sent information to integrated health clinics so she had not been able to follow up with a new primary care physician. Id.

The emergency department physician who saw plaintiff, Dr. Sarah Coleman, M.D., noted that plaintiff's social situation was very chaotic and this was contributing to her noncompliance. Id. At the time of her examination, plaintiff was somewhat disheveled,

but did not appear to be in acute distress. Id.

Plaintiff was given intravenous fluids and insulin while in the emergency room. Tr. 357. Dr. Coleman reported that plaintiff was doing much better once her blood sugars had come down. Id. A friend had volunteered to go pick up plaintiff's prescriptions for her. Id. Plaintiff requested Neurontin, used to treat nerve pain, for her neuropathy. Id. Because there were no records about whether she had tried this before, Dr. Coleman gave her a prescription for a small amount. Id. She also gave her ten Vicodin. Id. She encouraged plaintiff to follow through with a new primary care physician. Id.

On June 1, 2007, plaintiff saw John V. Allcott, M.D., of Applegate Medical East, for care of her diabetes and treatment of her neuropathy and depression. Tr. 297. Although there are indications plaintiff saw Dr. Allcott on May 4, 2007, no chart note from that visit appears in the Administrative Record. See Tr. 302 (noting vital signs such as weight, height, body mass index, blood pressure, and pulse, for May 4, 2007, June 1, 2007, and June 29, 2007); Tr. 297 (June 1, 2007 office visit chart note noting goals were "same as one month ago"); Tr. 299 (noting pain goals from May 4, 2007).

On physical examination, plaintiff was neatly dressed, mildly argumentative, and "exacting about her regimen." Tr. 299. Her mood was listed as no depression, anxiety, or agitation. Id. Her diabetic foot check showed dry and calloused feet. Id. Dr. Allcott noted that there was no improvement yet in plaintiff's peripheral neuropathy pain. Id.

At the time of the June 1, 2007 visit, plaintiff was taking

Neurontin for peripheral neuropathy, and methadone for neuropathy. Tr. 298. She was also taking the antidepressant Effexor for depression, and ibuprofen for back pain. Id.

Dr. Allcott doubled plaintiff's methadone dose from one ten-milligram tablet four times per day, to two ten-milligram tablets four times per day, and noted that plaintiff should return in four weeks to check her depression and pain relief. Tr. 298-99. He suggested she may need to eventually increase her dose. Id.

On June 9, 2007, plaintiff was treated at the emergency room of Sacred Heart Medical Center, and then admitted to the hospital until June 12, 2007. Tr. 315-34, 347-55. She was brought to the emergency room by ambulance after being found on the street in an altered mental status. Tr. 351. Id. She was difficult to arouse and mumbled incoherently. Id. The emergency room physician believed that she had taken an overdose of methadone, and concluded that plaintiff should be admitted to the hospital for further observation, and to allow her mental status to clear enough for plaintiff to be safe on the streets. Tr. 352; see also Tr. 347 (noting her admission to hospital for suspected overdose of methadone).

Plaintiff's discharge summary was written by Dr. Allcott. Tr. 354-55. He noted the high likelihood of polydrug interaction, including, possibly, the over usage of prescribed methadone. Tr. 354. Dr. Allcott noted that plaintiff herself denied any abuse or change in her methadone dosing. Tr. 355.

On June 29, 2007, plaintiff saw Dr. Allcott at his office. Tr. 293-95. At the time, she was still taking Neurontin for peripheral neuropathy, ibuprofen for back pain, methadone for pain,

and Effexor for depression, along with her diabetes medications. Tr. 294. At the visit, however, Dr. Allcott discontinued the prescription for Effexor, and does not appear to have added a substitute antidepressant, despite a notation that plaintiff had requested Klonopin or the benzodiazepine Xanax. Tr. 293-94. Dr. Allcott increased plaintiff's methadone dose from two ten-milligram tablets four times per day, to one forty-milligram tablet three times per day. Tr. 294-95. He recommended that she return in four weeks, but there are no records of additional visits.

II. Plaintiff's Testimony

Plaintiff testified at the February 2007 hearing that she had adult-onset diabetes, hepatitis C, severe neuropathy in both of her feet which was traveling up to her knees, and depression. Tr. 394. She stated that she attempted to take her life on November 19, 2005, and at other times which were not documented. Id.

Plaintiff stated that she was in a car accident in 2000 when she was knocked out. Tr. 395. However, she did not go to the hospital because she did not know she was hurt at the time. Tr. 406. According to plaintiff, the accident caused a radicular "thing" in her neck which has caused her pain since that time. Tr. 395. She described the pain as "horrible," including very tight muscles and a constant sound of "bone on bone," like a grinding sound. Id. Sometimes the pain radiates. Tr. 395-96. She gave an example of it starting in her right shoulder and rotating to her left hip. Id.

Plaintiff stated that her depression is evident because she "kind of just" doesn't care about things that used to interest her, such as long walks or bike rides. Tr. 397. She complained about

her teeth, noting that she had maybe seven teeth left. Tr. 398.

Plaintiff described her sleeping habits as "really bad." Id. She noted that one year earlier, she decided to stop taking all medications except insulin and blood pressure drugs because she did not want "anybody to ever be able to say that this was about drugs." Id. She admitted that in doing this, she did herself no favors. Id. She does not take naps. Id. Plaintiff's eating habits are "really bad," primarily because of her living and dental situations. Tr. 399.

Plaintiff stated that she would work if she could, but she was plagued by neuropathy, or alternatively, depression, which prevented her from working. Tr. 400-01. Because of her homelessness, plaintiff had a hard time describing her typical daily activities. Tr. 402-03. She said it depends on the day. Tr. 403. She was currently staying at someone's house, but she still experienced problems with staying clean and "together" such that she could look for a job. Id.

Plaintiff testified that she could stand for twenty or thirty minutes before needing to sit. Tr. 404. When asked how long she could walk without sitting down, plaintiff said it depends on the day, because "the day determines the neuropathy[.]" Id. She indicated that she did a lot of walking "out there," suggesting that sometimes she had no choice, even if it meant covering ten miles over the course of several hours and broken up by "other stuff[.]" Tr. 404-05.

Plaintiff guessed that the most she could lift was ten pounds, with the limitation caused by the "radicular thing," and problems with her shoulder, back, and neck. Tr. 417. She indicated that

she could lift a bag of groceries, and could probably carry a couple of gallons of milk, but not far. Tr. 418. Plaintiff also indicated that the neuropathy would prevent her from standing in a job such as waitressing. Tr. 421.

At the second hearing in September 2007, the ALJ asked plaintiff about the June 2007 Sacred Heart Hospital record noting that plaintiff had recently lost a position as a caregiver. Tr. 445. In response, plaintiff explained that in exchange for a "roof over my head[,]" she helped take care of a man who was severely manic depressive by making sure the house was clean and by cooking meals for him. Tr. 445.

III. Vocational Expert Testimony

Vocational Expert (VE) Kathleen O'Gieblyn testified at the February 2007 hearing. Tr. 429. The ALJ posed several hypotheticals to her, and plaintiff's counsel added limitations as well. Tr. 432-38. At the conclusion of the February 2007 hearing, the ALJ ordered that plaintiff receive consultative examinations. Tr. Tr. 438-40.

At the September 2007 hearing, the ALJ indicated that after considering the information from the consultative examinations, the earlier VE testimony provided by Ms. O'Gieblyn was in response to a hypothetical the ALJ now considered inappropriate. Tr. 446. Thus, he called a new VE expert, C. Kay Wise, as a witness at the September 2007 hearing. Id.

The ALJ presented the following hypothetical to the VE: someone of plaintiff's age, with one year of college, and with the same prior work as plaintiff. Tr. 448. The person would have the ability to stand or walk six hours in an eight-hour period, and had

no limitations in sitting or lifting. Id. The person needed to avoid dangerous hazards where there would be a risk of trauma. Id. The person would be limited to occasional ramp negotiation and stair climbing, ladder climbing and scaffold use, and crouching. Id. The person would be unable to understand, remember, and carry out detailed instructions, and would be intolerant of changes in the work setting. Id. The person would need a predictable stable routine, with little variation and simple tasks. Id. The person might have difficulty being consistent in her manner of relating with co-workers or the public, however, the person would still be capable of routine, superficial, or occasional interaction that does not require ongoing need for cooperative or collaborative teamwork interaction. Tr. 448-49. Finally, the person might also be unable to maintain a rapid pace or tasks where efficiency is a primary concern. Tr. 449.

In response, the VE testified that plaintiff could not perform her past relevant work as a legal secretary. Id. The ALJ asked if the VE could identify other work that would be appropriate at the medium level of exertion. Tr. 450. In response, the VE identified several jobs, including hand packager, library shelver, office helper, and addresser. Tr. 450-57.

THE ALJ'S DECISION

The ALJ first determined that plaintiff last met the insured status requirements of the Social Security Act on December 31, 2006. Tr. 23. He found that she did not engage in substantial gainful activity during the period from her alleged onset date of October 31, 2001, through the December 31, 2006 last insured date. Id.

> Next, the ALJ determined that plaintiff
>
> had the following severe combination of impairments: insulin-dependent (currently) diabetes mellitus with neuropathy, hepatitis C with normal albumin and normal bilirubin, . . . a dysthymic disorder, a pain disorder with psychological and medical factors, an anxiety disorder, a personality disorder with borderline/antisocial/dependent features, a history of substance abuse/dependence (methamphetamine, marijuana), a history of seizures with none for an extended period, and a history of reported cervical spine radiculopathy[.]

Tr. 24.

However, the ALJ further found that plaintiff did not have an impairment or combination of impairments that met or equaled a listed impairment. Tr. 27.

The ALJ next determined plaintiff's residual functional capacity (RFC). Tr. 28-32. The ALJ found that plaintiff could stand/walk for six hours in an eight-hour day, and had no limits on sitting or lifting. Tr. 28. He did find, however, that she could only occasionally crouch, climb ladders, ropes, or scaffolds, or climb ramps and stairs. Id. He found several non-exertional limitations, including avoiding dangerous hazards where there was a risk of trauma, an inability to understand, remember, or carry out detailed instructions, an intolerance of changes in the work setting, and the need for a predictable, stable, routine with little variation in performing simple tasks. Id. He also found that she might have difficulty being consistent in her manner of relations with co-workers or the public, but that she nonetheless was capable of routine, superficial, or occasional interactions that would not require an ongoing need for cooperative or collaborative teamwork interaction. Id. Finally, he found that she was unable to maintain a rapid pace or perform tasks where

efficiency was a prime concern. Id.

In reaching this RFC, as discussed more thoroughly below, the ALJ rejected much of plaintiff's subjective limitations testimony. Tr. 28-32. He further noted that because plaintiff's insured status expired at the end of 2006, any limitations noted in 2007 were relevant only if they could be demonstrated to have been in place in 2006. Tr. 32.

Based on his RFC, the ALJ determined that plaintiff could not return to her prior relevant work as a legal assistant. Tr. 32. Relying on the testimony of the VE, he determined, however, that there were jobs that existed in the significant numbers in the national economy that plaintiff could have performed, including hand packager, library shelver, office helper, and addresser. Tr. 32-33. Accordingly, the ALJ found plaintiff not disabled within the meaning of the Social Security Act. Tr. 33-34.

STANDARD OF REVIEW & SEQUENTIAL EVALUATION

A claimant is disabled if unable to "engage in any substantial gainful activity by reason of any medically determinable physical or mental impairment which . . . has lasted or can be expected to last for a continuous period of not less than 12 months[.]" 42 U.S.C. § 423(d)(1)(A). Disability claims are evaluated according to a five-step procedure. Baxter v. Sullivan, 923 F.2d 1391, 1395 (9th Cir. 1991). The claimant bears the burden of proving disability. Swenson v. Sullivan, 876 F.2d 683, 687 (9th Cir. 1989). First, the Commissioner determines whether a claimant is engaged in "substantial gainful activity." If so, the claimant is not disabled. Bowen v. Yuckert, 482 U.S. 137, 140 (1987); 20 C.F.R. §§ 404.1520(b), 416.920(b). In step two, the Commissioner

determines whether the claimant has a "medically severe impairment or combination of impairments." Yuckert, 482 U.S. at 140-41; see 20 C.F.R. §§ 404.1520(c), 416.920(c). If not, the claimant is not disabled.

In step three, the Commissioner determines whether the impairment meets or equals "one of a number of listed impairments that the [Commissioner] acknowledges are so severe as to preclude substantial gainful activity." Yuckert, 482 U.S. at 141; see 20 C.F.R. §§ 404.1520(d), 416.920(d). If so, the claimant is conclusively presumed disabled; if not, the Commissioner proceeds to step four. Yuckert, 482 U.S. at 141.

In step four the Commissioner determines whether the claimant can still perform "past relevant work." 20 C.F.R. §§ 404.1520(e), 416.920(e). If the claimant can, he is not disabled. If he cannot perform past relevant work, the burden shifts to the Commissioner. In step five, the Commissioner must establish that the claimant can perform other work. Yuckert, 482 U.S. at 141-42; see 20 C.F.R. §§ 404.1520(e) & (f), 416.920(e) & (f). If the Commissioner meets its burden and proves that the claimant is able to perform other work which exists in the national economy, he is not disabled. 20 C.F.R. §§ 404.1566, 416.966.

The court may set aside the Commissioner's denial of benefits only when the Commissioner's findings are based on legal error or are not supported by substantial evidence in the record as a whole. Baxter, 923 F.2d at 1394. Substantial evidence means "more than a mere scintilla," but "less than a preponderance." Id. It means such relevant evidence as a reasonable mind might accept as adequate to support a conclusion. Id.

DISCUSSION

Plaintiff contends that the ALJ erred by (1) failing to find that her depression is a severe impairment; (2) failing to find that her depression meets or equals a listed impairment; (3) rejecting her subjective testimony; and (4) failing to consider her combined impairments, and failing to consider her inability to sustain work performance, in making the RFC determination and as a result, failing to present a proper hypothetical to the VE. I address the arguments in turn.

I. Depression as a Severe Impairment

Although plaintiff alleges an onset date of October 31, 2001, there are no medical records before October 31, 2003. The first mention of depression in the record is plaintiff's self-report to Dr. Laurie on April 12, 2004. Tr. 167. Dr. Laurie noted her depression in the assessment and plan section of his progress note, but indicated that plaintiff wanted only her methadone. Tr. 168. There is no mention in his progress note from this date of any functional limitations attributable to her report of depression. Tr. 167-68. Dr. Laurie expressly stated that she was not suicidal. Tr. 167. Notably, at her next, and last, visit with Dr. Laurie on May 12, 2004, there was no mention of plaintiff's depression at all, either by plaintiff or by Dr. Laurie in any section of his progress note. Tr. 165-66.

The next mention of depression is in Dr. Baculi's April 7, 2006 chart note, the record of plaintiff's only visit with Dr. Baculi. Tr. 242-43. Plaintiff complained of an increased depressed mood, and reported having previously taken amitriptyline, but not in a number of years. Tr. 242. Dr. Baculi noted

"[p]ositive for depressed mood" in his "review of systems," but no specific information is provided regarding the basis for this statement and no limitations on plaintiff's functioning as a result of depression are noted. He prescribed amitriptyline for her. Tr. 243.

The issue of depression does not appear in the medical records again until plaintiff's consultative examination with Dr. Northway in March 2007, a date past her last insured date of December 31, 2006. Tr. 286. At the time, she described her mood as "mostly depressed." Id. Nonetheless, even though Dr. Northway had mentioned depression in his narrative, his primary Axis I diagnostic impression was dysthymic disorder. Tr. 290. He listed major depressive disorder, recurrent, moderate, only as a "rule-out" diagnosis. Id.[3]

In April 2007, also a date past her date last insured, Dr. Joffe assessed plaintiff not with major depression, but with a mood disorder due to a general medical condition. Tr. 253. Although Dr. Joffe suggested that the mood disorder was associated with both anxiety and depression, she did not assess plaintiff with major depressive order as outlined in the DSM IV-TR. Tr. 253 (Dr. Joffe's citation to DSM IV-TR diagnosis code of 298.83 for mood

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[3] The Diagnostic & Statistical Manual of Mental Disorders explains that differentiating between dysthymic disorder and major depressive disorder is difficult. American Psychiatric Association, Diagnostic & Statistical Manaul of Mental Disorders 379 (4th ed. Text Revision 2000) (DSM IV-TR). As noted there, however, major depressive disorder usually consists of one or more discrete major depressive episodes that can be distinguished from the person's usual functioning whereas dysthymic disorder is characterized by chronic, less severe symptoms that have been present for many years. Id.

disorder due to a medical condition); DSM IV-TR at pp. 401-05 (outlining diagnostic criteria for diagnosis of mood disorder due to a medical condition, with code number 298.83); see also Id. at p 376 (outlining diagnostic criteria for major depressive disorder, recurrent, bearing code number 296).

Later in April 2007, plaintiff was assessed by Patti Bear at Options Counseling, as having moderate major depressive disorder. Tr. 280. The DSM IV-TR code she used in defining the disorder, 296.22, indicates her diagnosis was for a single episode, not recurrent. See DSM IV-TR at p. 370 (which explains that in recording the diagnosis, the first three digits are 296, and the fourth digit is either "2" for a single major depressive episode, or "3" for recurrent major depressive episodes).

In June 2007, plaintiff saw Dr. Allcott. Tr. 298. Although he noted her depression, the DSM IV-TR code he used was not for major depressive disorder, but was number 300.4, the code for dysthymic disorder. DSM IV-TR at p. 376.

The ALJ reviewed the August 23, 2004 assessment by non-examining psychologist Paul Rethinger Ph.D. Tr. 26. The ALJ adopted Dr. Rethinger's conclusions that as of that time, plaintiff had nonsevere psychological impairments in the form of an anxiety disorder and a substance abuse disorder (methadone maintenance therapy and methamphetamine use), and that her psychological impairments created no restrictions in daily living, and only mild difficulties in maintaining social functioning, mild difficulties in maintaining concentration/persistence/pace, and no episodes of decompensation. Id.

The ALJ also relied on the February 28, 2005 assessment of the

evidence by non-examining psychologist Robert Henry, Ph.D. Id. Like Dr. Rethinger, Dr. Henry noted that there was insufficient evidence of any mental health problem until late October 2003 (Dr. Rethinger) or early 2004 (Dr. Henry). Id. Dr. Henry noted the lack of history of severe depression or anxiety issues, no mental hospitalizations, no concerns noted by a treating source, although plaintiff had reported a history of mental confusion. Id. He further noted that plaintiff was independent with her activities, drove, went for walks, watched television, and arranged dried flowers as a hobby. Tr. 26-27.

The ALJ also relied on Dr. Northway's March 2007 consultative examination. Tr. 27. He noted Dr. Northway's conclusions, including his diagnosis of dysthymic disorder. Tr. 27.

Based on these reports, the ALJ included the following mental-health related impairments in his list of "severe combination of impairments" at step two: dysthymic disorder, pain disorder with psychological and medical factors, anxiety disorder, and a personality disorder with borderline/antisocial/dependent features. Tr. 25.

Plaintiff argues that the ALJ erred in failing to acknowledge her depression as a severe impairment. Pltf's Mem. at p. 3. A severe impairment is one that significantly limits the claimant's physical or mental ability to do basic work activities. 20 C.F.R. §§ 404.1520(c). "Basic work activities" are the abilities and aptitudes necessary to do most jobs, including physical functions such as walking, standing, sitting, lifting, etc.. 20 C.F.R. §§ 404.1521(b). In Social Security Ruling (SSR) 96-3p (available at 1996 WL 374181, at *1), the Commissioner has explained that "an

impairment(s) that is 'not severe' must be a slight abnormality (or a combination of slight abnormalities) that has no more than a minimal effect on the ability to do basic work activities."

The Ninth Circuit has explained that the step two severity determination is expressed "in terms of what is 'not severe.'" Smolen v. Chater, 80 F.3d 1273, 1290 (9th Cir. 1996). The ALJ is required to consider the claimant's subjective symptoms, such as pain or fatigue, in determining severity. Id. Importantly, as the Ninth Circuit noted, "the step-two inquiry is a de minimis screening device to dispose of groundless claims." Id. (citing Yuckert, 482 U.S. at 153-54).

Here, the ALJ did conclude that plaintiff had a severe combination of impairments, including dysthymic disorder and other psychological conditions. This is not a case where the non-disability decision was made at step two. The ALJ went beyond step two.

The evidence of plaintiff suffering from depression as a separate, severe impairment before December 31, 2006, her last insured date, is minimal. There are two self-reports: one to Dr. Laurie in April 2004, and one to Dr. Baculi, two years later in April 2006. There is no objective evidence of depression from her alleged onset date of October 31, 2001, to her last insured date of December 31, 2006. There is no evidence that she suffered any limitations as a result of depression prior to that last insured date.

Moreover, the evidence after December 31, 2006, is not supportive of depression being a severe impairment before that date. Dr. Northway's primary Axis I diagnosis was dysthymic

disorder. Dr. Joffe's primary Axis I diagnosis was mood disorder based on an underlying medical condition. Dr. Allcott listed depression, but coded the diagnosis for dysthymic disorder. Bear also listed depression on April 18, 2007, but coded it as a single episode, not recurring, and thus, not relevant to the time period before plaintiff's last insured date.

Although the severe impairment analysis at step two is a screening device, the ALJ did not err in this case when he failed to list depression as a severe impairment. The evidence in the record does not establish that depression limited, much less significantly limited, plaintiff's mental ability to do basic work activities before December 31, 2006.

Alternatively, even if the ALJ erred, it was not prejudicial to plaintiff because the ALJ listed dysthymic disorder as a severe impairment and then incorporated all relevant limitations into his RFC. The DSM IV-TR describes the essential feature of dysthymic disorder as "a chronically depressed mood that occurs for most of the day more days than not for at least 2 years." DSM IV-TR at p. 376. During the periods of depressed mood, at least two of the following symptoms must be present: poor appetite or overeating, insomnia or hypersomnia, low energy or fatigue, low self-esteem, poor concentration or difficulty making decisions, and feelings of hopelessness. Id. Dysthymic disorder shares similar symptoms with major depressive disorder, but usually, major depressive disorder "consists of one or more discrete Major Depressive Episodes that can be distinguished from the person's usual functioning, whereas Dysthymic Disorder is characterized by chronic, less severe depressive symptoms that have been present for many years." Id. at

p. 379. Here, by finding that plaintiff's dysthymic disorder was a severe impairment, the ALJ recognized plaintiff's depressive mood as a severe impairment. This was sufficient based on the record.

Even assuming the ALJ should have considered plaintiff's depression, instead of her dysthymic disorder, as one of the severe impairments, such error was harmless. Lewis v. Astrue, 498 F.3d 909, 911 (9th Cir. 2007) (any error by ALJ in neglecting to list claimant's bursitis as a step two severe impairment was harmless when the ALJ considered the limitations caused by the impairment in assessing the claimant's RFC at step four). Here, as discussed further below, the ALJ's RFC incorporated several limitations attributable to plaintiff's psychological conditions, including (1) an inability to understand, remember, or carry out detailed instructions; (2) an intolerance of changes in the work setting; (3) a need for predictable, stable, routine with little variation in performing simple tasks; (4) difficulty being consistent in her manner of relations with co-workers or the public; (5) only occasional interactions with others that would not require an ongoing need for cooperative or collaborative teamwork interaction; and (6) an inability to maintain a rapid pace or perform tasks where efficiency was a prime concern. These RFC limitations sufficiently address any limitations supported in the record which are attributable to plaintiff's alleged depression.

II. Meet or Equal a Listed Impairment

Plaintiff argues that the ALJ erred by failing to find that her impairments met or equaled Listing 12.04, the listing for affective disorders. 20 C.F.R. pt. 404, subpt. P, app. 1, § 12.04.

The ALJ found that plaintiff's mental impairments, considered

singly, or in combination, did not meet or medically equal the criteria for Listings 12.04, 12.06, 12.07, 12.08, or 12.09. Tr. 27. The ALJ explained that plaintiff did not meet the Paragraph B or Paragraph C criteria required for the listings.

Listing 12.04 provides, in pertinent part:

> *Affective Disorders*: Characterized by a disturbance of mood, accompanied by a full or partial manic or depressive syndrome. Mood refers to a prolonged emotion that colors the whole psychic life; it generally involves either depression or elation.
>
> The required level of severity for these disorders is met when the requirements in both A and B are satisfied, or when the requirements in C are satisfied.
>
> A. Medically documented persistence, either continuous or intermittent, of one of the following:
>
> * * *
>
> AND
>
> B. Resulting in at least two of the following:
>
> 1. Marked restriction of activities of daily living; or
>
> 2. Marked difficulties in maintaining social functioning; or
>
> 3. Marked difficulties in maintaining concentration, persistence, or pace; or
>
> 4. Repeated episodes of decompensation, each of extended duration;
>
> OR
>
> C. Medically documented history of a chronic affective disorder of at least 2 years' duration that has caused more than a minimal limitation of ability to do basic work activities, with symptoms or signs currently attenuated by medication or psychosocial support, and one of the following:
>
> 1. Repeated episodes of decompensation, each of extended duration;
>
> 2. A residual disease process that has resulted in such marginal adjustment that even a minimal increase in mental demands or change in the environment would be predicted to cause the individual to decompensate; or
>
> 3. Current history of 1 or more years' inability to function outside a highly supportive living arrangement, with an indication of continued need for such an arrangement.

20 C.F.R. pt. 404, subpt. P, app. 1, § 12.04.

The ALJ concluded that plaintiff had moderate restrictions in activities of daily living, and moderate difficulties in social functioning and in maintaining concentration, persistence, or pace. Tr. 27. He further concluded that she had experienced only one or two episodes of decompensation. Id. He concluded that because she did not have at least two marked limitations, or one marked limitation with repeated episodes of decompensation, the Paragraph B criteria were not met. Tr. 27-28. He further concluded that the Paragraph C criteria were also not met. Tr. 28.

Plaintiff argues that the record shows that she has marked restrictions of activities of daily living, marked difficulties in maintaining social functioning, marked difficulties in maintaining concentration, persistence, or pace, and probable repeated episodes of decompensation. Pltf's Mem. at p. 16. She contends that these marked limitations are caused by the "presence of depressive syndrome characterized by anhedonia/pervasive loss of interest in almost all activities, sleep disturbance, decreased energy, feelings of worthlessness, difficulty concentrating or thinking, [and] thoughts of suicide." Id.

In support of this argument, plaintiff cites to only two reports which pre-date her last insurance date. One is her husband's July 18, 2004 report in which he states that plaintiff "talks about death all the time[.]" Tr. 117. The other is plaintiff's "Disability Report-Appeal" dated October 18, 2004. Tr. 121-27. In that report, plaintiff relies on her statement that she was "becoming more and more depressed," and that she had given up her nightly walks because she was "apathetic about the illness

because life itself is too difficult." Tr. 121, 125.

Even disregarding the ALJ's rejection of plaintiff's subjective testimony, discussed below, none of these three statements establish a marked limitation in any of the relevant "B" criteria. They also do not establish repeated episodes of decompensation, and they fail to establish any of the "C" criteria.

The rest of the medical record evidence cited by plaintiff in support of this step three argument, is from after her last insurance date of December 31, 2006. She relies on her subjective statements to Dr. Joffe in late March and early April 2007, in which, in response to a question about how she feels most of the time, plaintiff wept and said she felt like "shit." Tr. 251. She also told Dr. Joffe that she cut herself with a razor in 2004, causing her to be kicked out of a shelter. Tr. 252.

Plaintiff notes that Dr. Joffe stated that under stress, plaintiff's behavior would be expected to deteriorate and that people with her profile are often anxious and experience sleep disturbance, difficulty concentrating, confused thinking, and forgetfulness. Tr. 253. Dr. Joffe also explained, in the narrative portion of her report, that plaintiff's ability to understand and remember complicated instructions would fluctuate depending on how much sleep she had the night before and her blood sugars. Tr. 254.

Plaintiff relies on other statements she made to Dr. Northway and Bear, also in March and April 2007, as well as her statements at her February 2007 hearing that she had attempted to take her own life and just wanted to sleep constantly. However, as explained below, the ALJ justifiably found plaintiff not credible. As a

result, her subjective complaints to mental health practitioners do not establish the marked limitations required for a listed impairment.

Dr. Joffe completed an assessment of plaintiff's ability to do work-related activities. Tr. 255-57. She indicated that plaintiff's ability to understand and remember detailed instructions, and her ability to carry out detailed instructions, was moderate or marked, depending on plaintiff's blood sugar. Tr. 255. She wrote that plaintiff was able to understand the instructions for the MMPI-2, for example, but took four hours to complete it. Id. She explained that it appeared that plaintiff's ability to understand, remember, and carry out instructions was affected by her fatigue and blood sugar fluctuations. Id.

Dr. Joffe also indicated that plaintiff had a marked impairment in responding appropriately to work pressures in a usual work setting. Tr. 256. But, she explained that if plaintiff's blood sugar was well maintained, she would have fewer difficulties with social interaction. Id. If her blood sugars were not well maintained, or if plaintiff were under pressure, she would have difficulty performing appropriately. Id.

The ALJ noted that plaintiff's fatigue, was not, on the record before him, attributable to a medical condition, but to her living situation. Tr. 32. He noted that plaintiff explained her fatigue to Dr. Northway as being the result of homelessness for several days and being out of medication, and later, as a result of having been out until 4:00 a.m. looking for her husband. Id. He also noted that plaintiff's report to Dr. Joffe was that she had slept outside the prior night and thus, did not get to sleep until 3:30

a.m., and was awakened at 6:30 a.m. Id.

To the extent Dr. Joffe's "marked" assessments were based on plaintiff's fatigue, they are not supportive of a physically- or mentally-based limitation. Additionally, Dr. Joffe's "marked" assessments do not establish the "B" criteria. Those criteria require marked restrictions in two of the following abilities: (1) activities of daily living; (2) maintaining social functioning; or (3) maintaining concentration, persistence, or pace. Dr. Joffe's moderate to marked limitations are in the abilities to (1) understand and carry out detailed instructions; and (2) respond appropriately to pressure in a work setting. These are not the "B" criteria.

Finally, as the ALJ noted, because plaintiff's insured status expired at the end of 2006, any limitations noted in 2007 were relevant only if they could be demonstrated to have been in place in 2006. Tr. 32.

The ALJ's determination at step three is supported by substantial evidence in the record. The evidence cited by plaintiff as establishing the required criteria for Listing 12.04 is either properly discredited subjective testimony, unsupportive of the relevant criteria, or a post-last insured date assessment of her functions.

III. Plaintiff's Credibility

The ALJ found plaintiff's subjective testimony not credible. The ALJ is responsible for determining credibility. Andrews v. Shalala, 53 F.3d 1035, 1039 (9th Cir. 1995). Once a claimant shows an underlying impairment and a causal relationship between the impairment and some level of symptoms, clear and convincing reasons

are needed to reject a claimant's testimony if there is no evidence of malingering. Smolen, 80 F.3d at 1281-82.

When determining the credibility of a plaintiff's complaints of pain, the ALJ may properly consider several factors, including the plaintiff's daily activities, inconsistencies in testimony, effectiveness or adverse side effects of any pain medication, and relevant character evidence. Orteza v. Shalala, 50 F.3d 748, 750 (9th Cir. 1995). The ALJ may also consider the ability to perform household chores, the lack of any side effects from prescribed medications, and the unexplained absence of treatment for excessive pain when determining whether a claimant's complaints of pain are exaggerated. Id.

The ALJ discussed several bases upon which to discredit plaintiff's testimony. First, he discussed the evidence related to the alleged car accident that plaintiff cited as the cause of her disabling radiculopathy. Tr. 29. The ALJ noted plaintiff's statement that she did not realize at the time of the accident that she was hurt, and thus did not seek prompt medical attention. Id. The ALJ then noted plaintiff's testimony describing the accident as one in which her head went forward and hit the windshield, then she fell back in her seat and her head flopped around like a rag doll, and she was knocked out. Id. The ALJ stated that plaintiff's description of the accident was inconsistent with her statement that she did not realize she was hurt. Id.

The ALJ then cited to plaintiff's testimony that her then-primary care practitioner Dr. Reeves, told her she had radiculopathy. But, as the ALJ had already noted in his opinion, a request for plaintiff's records from October 1, 1999, to the

present, was sent to Dr. Reeves's office on July 23, 2004. Tr. 26 n.1. It was returned and annotated "No Records Available" for the time period identified. Id.; Tr. 172.

The ALJ also rejected plaintiff's testimony about her severity of her radiculopathy pain because, although she has problems comfortably lifting heavy items, she testified that she can lift a bag of groceries or carry a couple of gallons a milk for a short distance. Tr. 29. He further noted that there was a lack of objective findings from tests such as nerve conduction studies, x-rays, or MRIs, that would provide substantial support for her alleged physical impairments. Tr. 31.

Next, the ALJ noted the lack of any medical record of her alleged suicide attempt which, at the February 2007 hearing, plaintiff testified occurred on November 19, 2005. Tr. 30.[4] At the time, plaintiff was under the care of Dr. Tollerton, and there is no mention of any suicide attempt in his chart notes, nor is there any hospital record affirming such an attempt.

The ALJ then discussed plaintiff's voluntary cessation of medications which she testified thought would help her obtain disability benefits. Tr. 31. Plaintiff's decision in this regard was especially revealing to the ALJ. He noted that first, it raised the issue of unacceptable medical noncompliance with prescribed treatment that would reasonably improve her symptomatology and functioning. Tr. 31. He further noted that it

[4] Plaintiff told Dr. Joffe that this occurred in 2004, not 2005. Tr. 252. In November 2004, plaintiff was under the care of Dr. Meyers and the chart notes reveal nothing about a suicide attempt.

would also "make it inherently probable that medical opinions about the nature/severity of the claimant's impairments will not accurately portray the claimant's true capabilities. Id. He concluded that "otherwise valid objective psychological testing . . . must be given reduced weight since the claimant has handicapped herself through noncompliance with medications." Id. The noncompliance suggests that "the claimant was not so limited as to see the need to aggressively pursue remedies." Id.

Next, the ALJ determined that plaintiff's history of polysubstance abuse suggested "patterns of duplicity/evasion/misdirection." Id. He then noted that discrepancies had been found in physical examinations. Id. He cited to Dr. Brewster's observation of plaintiff spontaneously abducting her arm to 170 degrees while hanging up her coat, but her statement during the actual exam by Dr. Brewster that she could not abduct it more than 80 degrees. Id. Finally, the ALJ noted that plaintiff reported that she had been fired in the past, for stealing, and that she acknowledged that she was jailed for eight days for stealing food in 2004. Id.

The ALJ then concluded that "[b]ased on this combination of factors, the claimant's statements concerning her impairments and their impact on her ability to work are accepted only to the extent that they are consistent with the residual functional capacity assessment arrived at above." Id.

Plaintiff contends that the ALJ erred by relying on plaintiff's alleged noncompliance with her medications. With no citation to any particular medical record, plaintiff argues that the record establishes that she continues to be ill and

significantly impaired even when taking her prescribed medications. She also argues that the record shows that her noncompliance was related to her financial circumstances, the medications being stolen, or her belief that they made her worse. Tr. 263 (reporting to Dr. Brewster that she could not afford her oral diabetes medication and was on and off of it); Tr. 279 (reporting that her medications had been stolen); Tr. 167 (reporting that she did not want to take antidepressants because they made her depression worse); see also Tr. 269 (Dr. Brewster noting that plaintiff's homelessness might make storage of medication difficult and affect compliance).

The record supports the ALJ. First, the ALJ cited plaintiff's willful noncompliance as the basis for discrediting her testimony, not the times when she was unable to obtain medications because of financial problems or other reasons beyond her control. Tr. 31 (discussing the "claimant's reporting that she had intentionally discontinued medications, as she felt this would be helpful in her attempt to get Social Security benefits").

Second, Dr. Calder's chart notes indicate that when plaintiff understood her disease and complied with medications, her diabetes became more controlled. E.g., Tr. 190-91, 193, 196-96, 197-200; see also Tr. 269 (Dr. Brewster stating that the records showed that when plaintiff adhered to her insulin, she was able to manage her diabetes). And, despite her statement to Dr. Laurie that she did not take antidepressants because they made her more depressed, she obtained a prescription for amitriptyline from Dr. Baculi in April 2006, and took Effexor prescribed by Dr. Allcott, suggesting that she believed the antidepressant drugs helped her. Tr. 242-43, 298.

Thus, the record supports the ALJ's determination that the absence of medication did affect plaintiff's impairments.

Plaintiff next argues that the ALJ's reference to plaintiff's possible methamphetamine use was prejudicial to any assessment of her condition and interfered with an accurate assessment of her impairments. The ALJ discussed some of the evidence regarding plaintiff's history of drug use. Tr. 31. Specifically, he noted that plaintiff testified that she was not using methamphetamine, but rather, had taken what she had been told was a weight loss/diet pill. Tr. 30. The ALJ further noted that plaintiff was told she was taking an amphetamine after she had her blood checked. Id. The ALJ then remarked that plaintiff told Dr. Northway that she never "willingly used methamphetamine" but had taken what she thought was a weight loss drug. Id. The ALJ noted that plaintiff had reported to Dr. Northway that she had tried a number of street drugs in the past, had tried heroin many years previously, and had become addicted to narcotics in the early 1980s. Id. Finally, regarding her drug history, the ALJ stated that plaintiff had stated that her last use of marijuana was six months previously, but she was hoping to get her current physician to sign a medical marijuana card so she could use it to help with her pain. Id.

Thereafter, the ALJ concluded that plaintiff's history of polysubstance abuse suggested a pattern of "duplicity/evasion/misdirection." Tr. 31. The way I interpret the ALJ's opinion is that he (1) concluded that her drug history alone made her not credible, or, (2) found her testimony inconsistent and thus, supportive of his finding that her drug abuse suggested a pattern of duplicity, evasion, and misdirection.

I agree with plaintiff that the ALJ's finding which correlated plaintiff's polysubstance abuse to a pattern of duplicity, etc., is not entirely supported by the record. In response to a question from the ALJ inquiring if it was correct that she was using methamphetamine at one point, plaintiff testified at the February 2007 hearing that she did not knowingly take methamphetamine, but instead, took what she thought was a diet pill. Tr. 409-10. Despite losing a fair amount of weight, plaintiff was surprised to learn, when her blood was checked, that she had been taking an amphetamine. Tr. 412.

While the explanation may have been difficult for the ALJ to believe, her testimony on this issue is not inconsistent with other parts of the record. See, e.g., Tr. 285 (report to Dr. Northway which is consistent with her hearing testimony).

Additionally, although plaintiff has a history of drug use, it is unclear why plaintiff's statement that she last used marijuana six months ago would be inconsistent with her statement that she was applying for a medical marijuana card in an attempt to use marijuana legally to control pain. There is, again, no contrary evidence in the record. I agree with plaintiff that her past history of illicit drug use does not, by itself, support a negative credibility determination.

Nonetheless, the ALJ has given several supportable reasons to reject plaintiff's testimony. Not all of the reasons for discrediting a claimant must be upheld, as long as substantial evidence supports the ALJ's determination. Batson v. Commissioner, 359 F.3d 1190, 1197 (9th Cir. 2004). Here, the ALJ noted the lack of objective findings in the record to support her complaints, the

inconsistency in her testimony regarding the circumstances of her alleged 2001 car accident, the lack of evidence supporting her alleged attempted suicide, the discrepancies in her abilities on physical examination compared with observation, the discrepancies in her stated limitations compared with her daily activities (such as what she could carry, and the fact that at one point, she still went for walks and had hobbies), and her history of theft, which is suggestive of unreliability.

Substantial evidence supports the ALJ's rejection of plaintiff's subjective testimony regarding her pain and functional limitations.

IV. RFC

As noted above, plaintiff argues that the ALJ erred by failing to consider her combined impairments and her inability to sustain work performance, in determining her RFC. She contends that the ALJ failed to consider the "interplay" of plaintiff's depression-related limitations with her physical impairments and pain. She argues that the evidence shows that she requires a "tremendous degree of flexibility in her job," including taking breaks whenever necessary and leaving early or being absent at least two times per month. Pltf's Mem. at p. 8. She also argues that her difficulty coping with stressors found in a competitive work environment would result in frequent episodes of decompensation of extended duration. Id. at pp. 8-9.

The ALJ explained that the record did not include objective evidence supporting plaintiff's alleged physical limitations. Tr. 31. He specifically noted the absence of nerve conduction studies, x-rays, or MRIs that would support her alleged physical

impairments. Id. He also noted discrepancies in her stated functional limitation and what was observed by a physician. Id. (citing Dr. Brewer's observation of plaintiff spontaneously abducting her arm to 170 degrees spontaneously, but claiming on testing, that she could not abduct it more than 80 degrees. Tr. 269). The ALJ further disregarded the references by Dr. Northway and Dr. Joffe to plaintiff's fatigue and sluggishness for the reasons discussed above. Id.

Notably, plaintiff cites to no physical limitations assessed by any treating, examining, or non-examining health care practitioner based on her alleged radiculopathy or neuropathy. She also points to no limitations assessed by a mental health practitioner prior to the date she was last insured. Dr. Joffe's limitations, as previously discussed, which are moderate to marked, in a couple of categories, were assessed after the last insured date. Plaintiff cites to no evidence in support of her position that her impairments mandate breaks from the workday at will, leaving early, and periodic absences.

I need not repeat here the discussions related to plaintiff's arguments regarding the severity of her depression and her credibility. I incorporate them, however, because given the ALJ's conclusions on those issues, which are supported by substantial evidence, together with the ALJ's independent discussion of her RFC and the reasons articulated by the ALJ in support of the RFC, the ALJ's RFC is supported by substantial evidence in the record. Because the RFC is supported, the hypothetical given to the VE was not in error.

CONCLUSION

The Commissioner's determination of non-disability should be affirmed.

SCHEDULING ORDER

The Findings and Recommendation will be referred to a district judge. Objections, if any, are due August 28, 2009. If no objections are filed, then the Findings and Recommendation will go under advisement on that date.

If objections are filed, then a response is due September 11, 2009. When the response is due or filed, whichever date is earlier, the Findings and Recommendation will go under advisement.

IT IS SO ORDERED.

Dated this 13th day of August, 2009.

/s/ Dennis James Hubel
Dennis James Hubel
United States Magistrate Judge